

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wilmer Berton Atkinson			2a. DATE OF DEATH MONTH DAY YEAR December 15, 1980		2b. HOUR P M 12:30 P		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fruit Salesman		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Worton	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Berton Atkinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elma Rebecca Bigelow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>5570 Probable mesothelioma with thrombosis & embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>atrial fibrillation - severe heart failure</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December 7</u> , 19 <u>80</u> , to <u>December 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>December 15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Robert W. Farr</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert W. Farr, M.D.				22e. ADDRESS Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/80		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME <i>Walls, Wells</i>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 18 1980	
				25b. REGISTRAR'S SIGNATURE <i>L. J. McCreedy</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

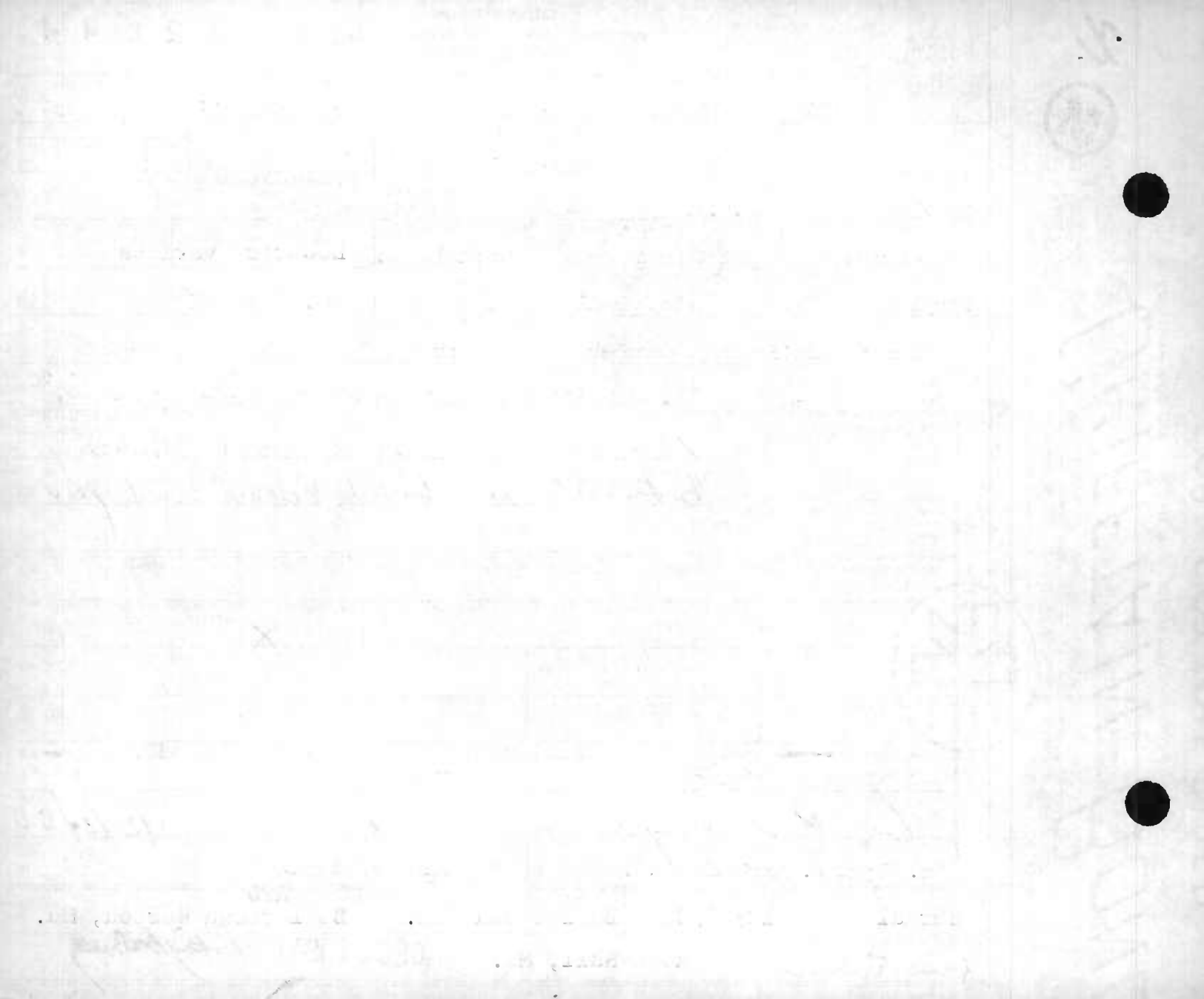
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ella Elaine Chambers			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1980			2b. HOUR P M 10:54 P M				
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR December 31, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Loboror		12b. KIND OF BUSINESS OR INDUSTRY various		
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rte.#2 Box 147	
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Chambers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma Pauline Hackett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland 21620					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 year</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (did not) attended the deceased from <u>December 25</u> , 19 <u>80</u> , to <u>December 25</u> , 19 <u>80</u> , that (I) (was not) last saw the deceased alive on <u>December 25</u> , 19 <u>80</u> , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Wayne D. Benjamin, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>12/24/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wayne D. Benjamin, M.D.						22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/80		23c. NAME OF CEMETERY OR CREMATORY Butlertown Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Butlertown Worton, Md.			
24. FUNERAL DIRECTOR NAME <u>James Perkins</u>						25. DATE OF CO. BY REG. STRAR DEC 31 1980		26. REG. STRAR'S SIGNATURE <u>[Signature]</u>		



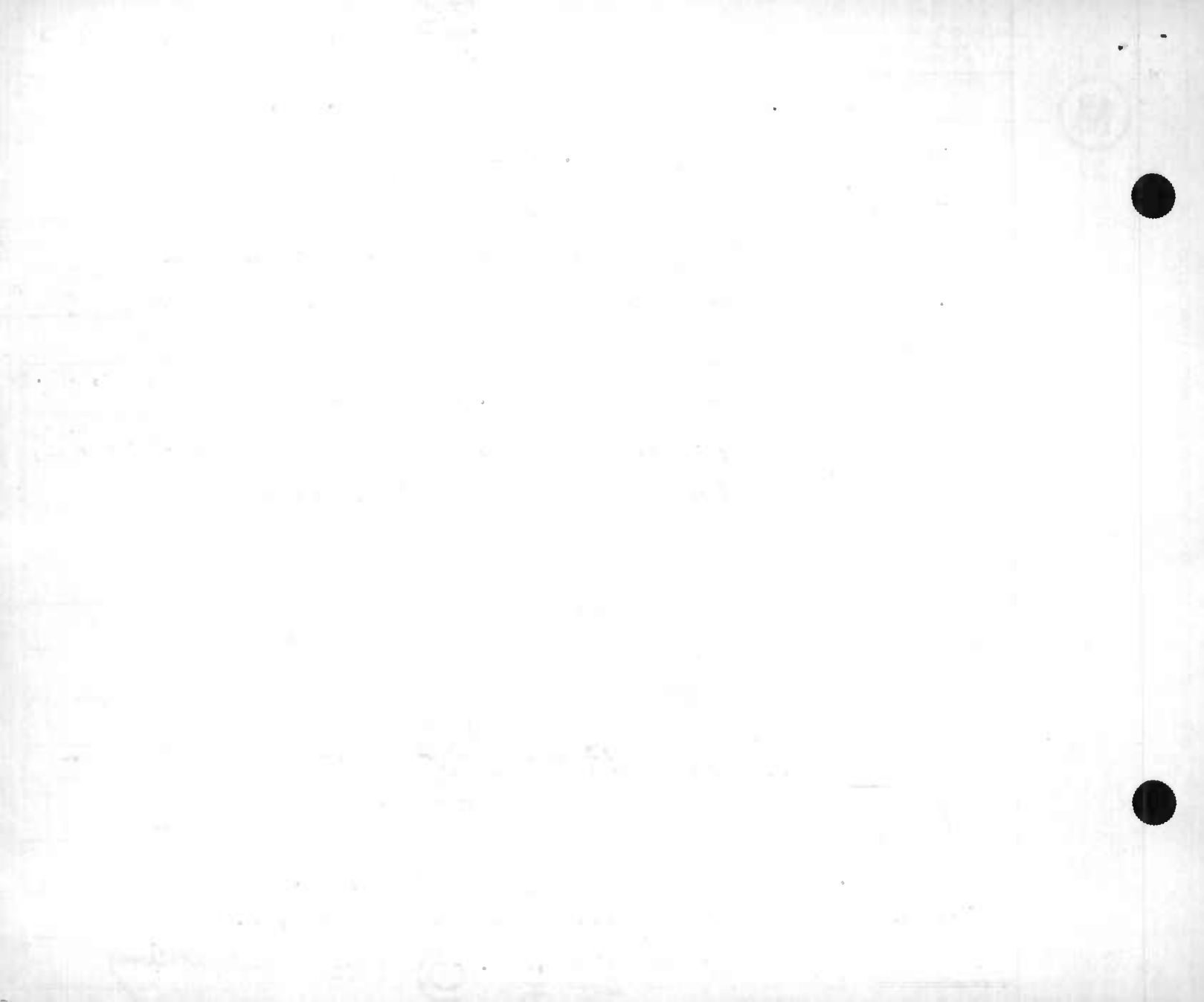
TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	3	2	3	4	5		
1. FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Helen H. Clark										2a. DATE OF DEATH Dec. 23, 1980				2b. HOUR 7		p.m.		
3. SEX female			4. RACE white			5. DATE OF BIRTH Aug. 2, 1890			6. AGE (IN YEARS LAST BIRTHDAY) 90			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent									
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Schoolteacher			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Kent		13c. CITY OR TOWN Betterton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Fair Promise Farm		
14. FATHER'S NAME George Higgins					15. MOTHER'S MAIDEN NAME Margaret Rowand					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 136 30 5955		17. INFORMANT Mrs. Robert Clark	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Wall Myocardial Infarction</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Due to, or as a consequence of</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>< 24 hrs.</u>								
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>80</u> , to <u>12-23</u> , 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>12-23</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.										22b. SIGNATURE <u>Wayne D. Benjamin</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin					22e. ADDRESS Chestertown, Md.													
23a. BURIAL, CREMATION, REMOVAL (IF BY)			23b. DATE 12/27/80		23c. NAME OF CEMETERY OR CREMATORY Berlin Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Berlin, N. Jersey										
24. FUNERAL DIRECTOR NAME <u>W. L. Wells</u>					24b. ADDRESS Chestertown, Md.					25a. DATE REC'D. BY REGISTRAR DEC 31 1980		25b. REGISTRAR'S SIGNATURE <u>Robert H. H. H.</u>						

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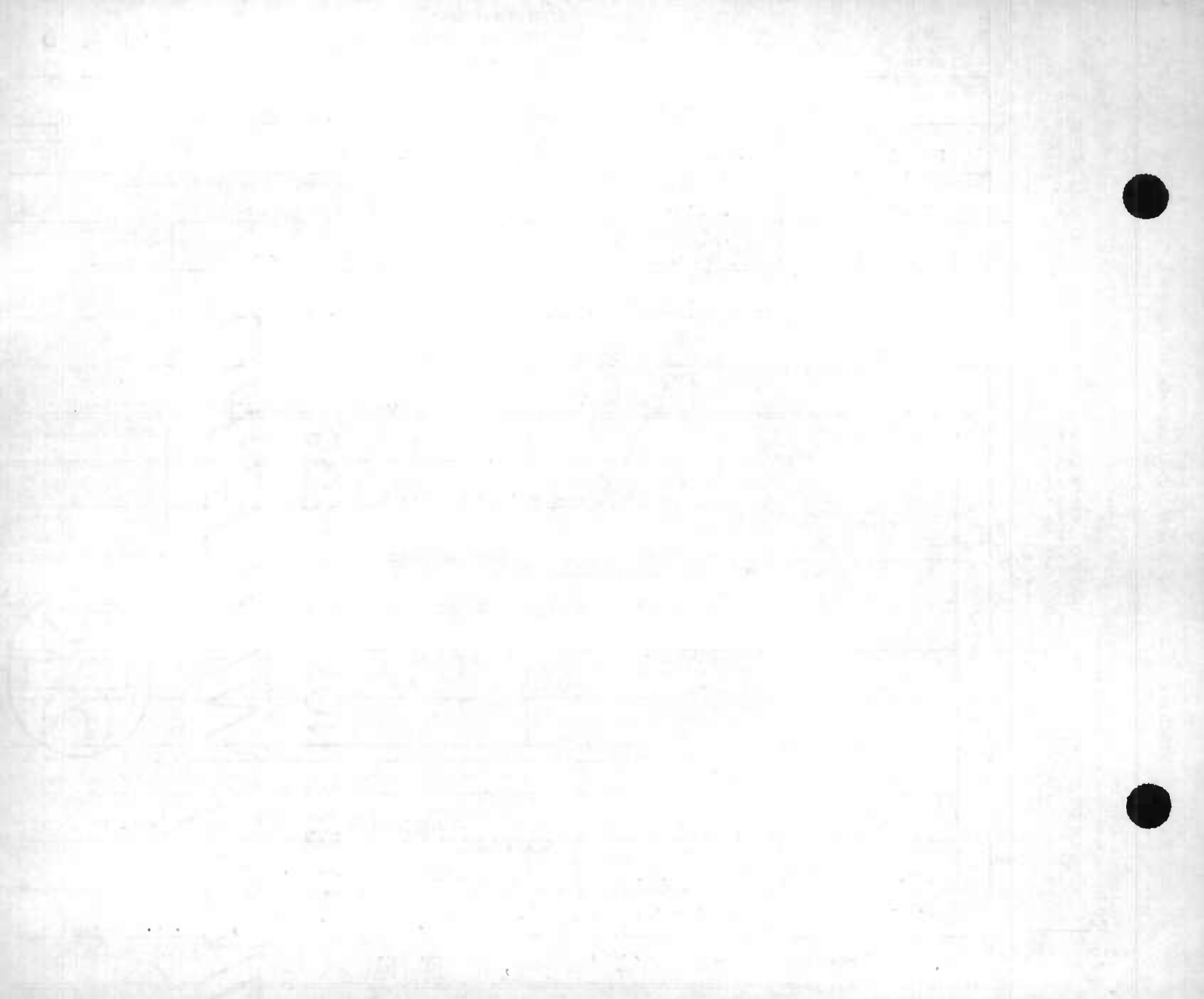
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 3 2 3 4 6
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Grace Clark		2a. DATE OF DEATH MONTH DAY YEAR December 22, 1980	
3 SEX Female		2b. HOUR 8:00 P.M.	
4 RACE Negro		6 AGE (IN YEARS LAST BIRTHDAY) 85	
5. DATE OF BIRTH MONTH DAY YEAR September 2, 1895		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Maryland		13b. COUNTY Kent	
13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS P.O. Box 231		15. MOTHER'S MAIDEN NAME Alice Wilmore	
14. FATHER'S NAME FIRST MIDDLE LAST Georgia Bratcher		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 221-14-4752		17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Colloyme DUE TO, OR AS A CONSEQUENCE OF (b) Massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 4100		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr. 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from December 19, 1980 to December 22, 1980 , that (I) (we) last saw the deceased alive on December 22, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Thomas J. Solon		DEGREE M.D.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas J. Solon, M.D.		22d. ADDRESS Chestertown, Maryland 21620	
22e. DATE SIGNED 12/23/80		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/27/80	
23c. NAME OF CEMETERY OR CREMATORY Pondtown Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pontown, Q.A. MD	
24. FUNERAL DIRECTOR NAME Edw. Fellows and Son		25a. DATE REC'D. BY REGISTRAR DEC 29 1980	
25b. REGISTRAR'S SIGNATURE Henry R. Reddy		25c. ADDRESS Millington, MD 21620	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 2 3 4 7 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) Helen Beatrice COLEMAN			
2. DATE OF DEATH MONTH DAY YEAR Dec. 30, 1980				2b. HOUR 1 A.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD Piney Neck (At Home)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Bennett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Hynson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-16-9795		17. INFORMANT ADDRESS Ernest Coleman RFD Piney Neck Rock Hall, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycocardial Infarction</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>years</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1/77</u> 19 <u>75</u> , to <u>12/7</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>12-9</u> 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <u>Wayne D. Benjamin</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 12/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin, M.D.				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 1, 1981		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.	
24. FUNERAL DIRECTOR NAME <u>Wallis Wells</u>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JAN 7 1981	
				25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

IN REPLY TO

RECEIVED

DEC 11 1963

NOV 10 1963

USA

(NO NAME)

NOV 10 1963

NOV 10 1963

NOV 10 1963

X

10/17/63 12/7

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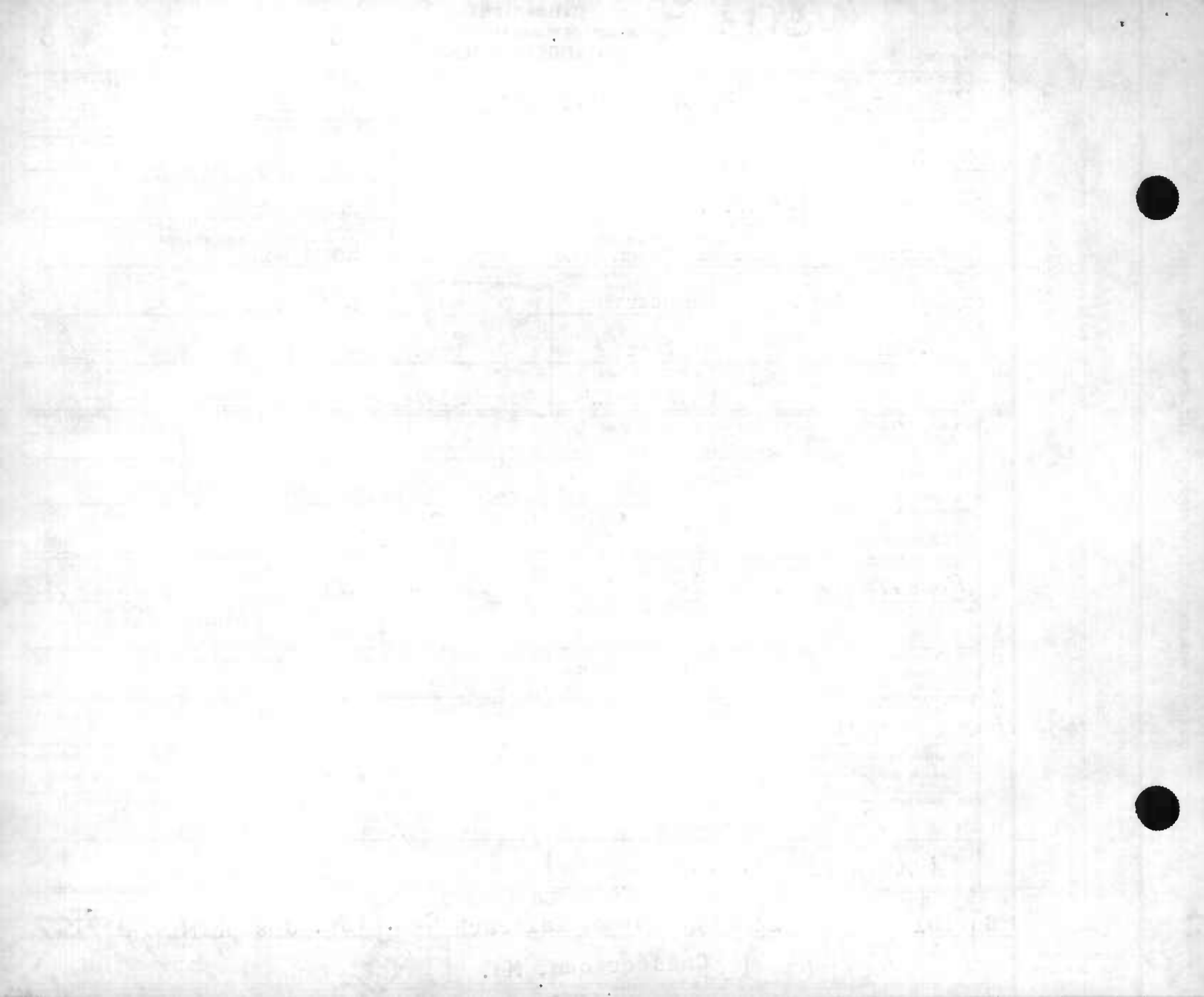
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 4 8			
1- FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT) THELMA EOLA COPELAND					2a DATE OF DEATH December 1, 1980				2b HOUR 11:50 PM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH December 3, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7a MONTH December		7b DAY 1			
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7d CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.							
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Kent and Queen Anne's Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE Maryland				13b COUNTY Kent		13c CITY OR TOWN Chestertown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 3 Box 205			
14 FATHER'S NAME John NMN Booth				15. MOTHER'S MAIDEN NAME Mary Moore Francis									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 088-05-1294		17 INFORMANT ADDRESS Hospital Records Chestertown, Maryland 21620							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic intractable congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): (1) <u>Obstructive arterial disease</u> (2) <u>Diabetes mellitus</u> (3) <u>Bronchial Asthma</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from <u>October 20</u> , 19 <u>80</u> , to <u>12/1</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>12/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE K. K. Wun				DEGREE				22c DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN M.D.				22e ADDRESS Chestertown, Maryland 21620									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/4/80		23c NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d LOCATION CITY OR TOWN COUNTY STATE St. Joseph Missouri MO							
24 FUNERAL DIRECTOR NAME J. Wilho Wells				ADDRESS Chestertown, Md.		25a DATE REC'D. BY REGISTRAR DEC 8 1980		25b REGISTRAR'S SIGNATURE H. J. McCready					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

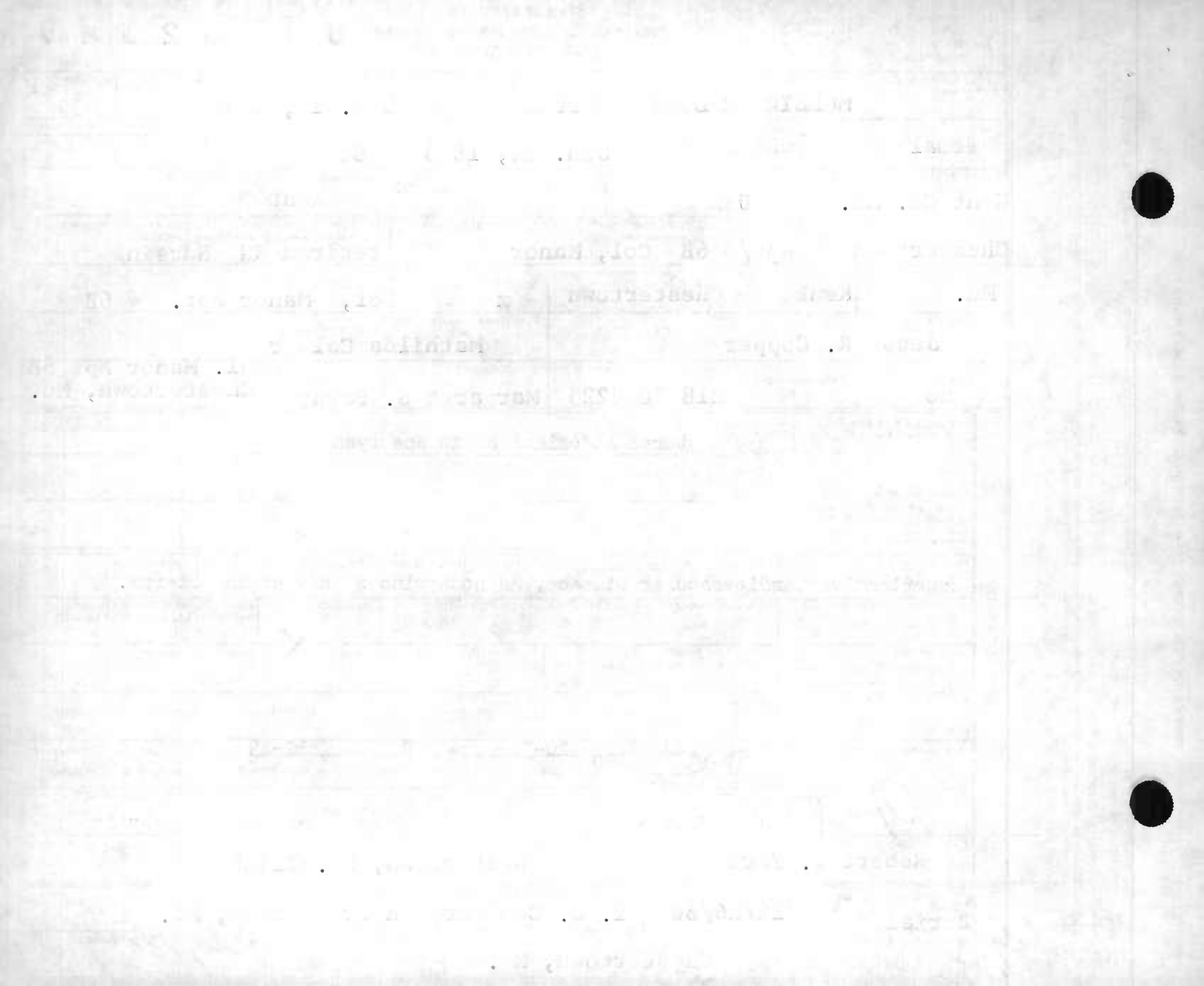
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	3	2	3	4	9
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) MOLLIE CALDER COPPER										2a. DATE OF DEATH MONTH DAY YEAR Dec. 13, 1980				2b. HOUR 5:30		P M
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1898			6. AGE (IN YEARS LAST BIRTHDAY) 82			7. UNDER 1 YEAR MONTHS DAYS YRS.		7. UNDER 24 HRS HOURS MIN YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent							
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Apt./# 6B Col, Manor						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired RN				12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Chestertown			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS Col, Manor Apt. # 6B							
14. FATHER'S NAME FIRST MIDDLE LAST Jesse R. Copper						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mathilda Calder										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218 30 2225			17. INFORMANT ADDRESS Margaret S. Payne Col. Manor Apt 6B Chestertown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Abdominal Aorta Aneurysm										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4413 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive Cardiovascular Disease, Adenocarcinoma body of the Uterus.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 12-13 19 80 to 10-3 19 59 , that (I) (we) last saw the deceased alive on 12-13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (that) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Robert W. Farr</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-15-80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr						22e. ADDRESS Chestertown, Md. 21620										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/16/80			23c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery near Worton, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR <i>W. Willis Wells</i>						ADDRESS Chestertown, Md.				25. DATE REC'D. BY REGISTRAR DEC 22 1980		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

BP



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 5 0			
1- FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT) HETTIE O. CREW					2a DATE OF DEATH MONTH DAY YEAR Dec. 14, 1980				2b HOUR 6:40 A M				
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Jan 28, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.							
10 CITY OR TOWN OF DEATH Betterton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Kent		13c CITY OR TOWN Betterton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS P.O. Box 56					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph H. Crew					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Young								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 30 9545		17 INFORMANT ADDRESS Va. Curlett - Betterton, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) A.S.C.V.D. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (1) (this hospital) attended the deceased from 6 Decemr 1980 to 14 DEC. 1980 , that (1) (we) lost saw the deceased alive on Sept 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b SIGNATURE Harry Paul Ross		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 14 Dec 1980					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross				22e ADDRESS Chestertown, Md. 21620									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/16/80		23c NAME OF CEMETERY OR CREMATORY Still Pond Cem.				23d LOCATION CITY OR TOWN COUNTY STATE Still Pond, Md.					
24 FUNERAL DIRECTOR NAME William Wells				ADDRESS Chestertown, Md.				25a DATE REC'D. BY REGISTRAR DEC 22 1980		25b REGISTRAR'S SIGNATURE <i>Robert M. ...</i>			

2-2-3

U.S. DEPARTMENT OF JUSTICE

RECEIVED

U.S. DEPARTMENT OF JUSTICE

Jan 18, 1930

US

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE - BUREAU OF PRISONS

U.S. DEPT. OF JUSTICE

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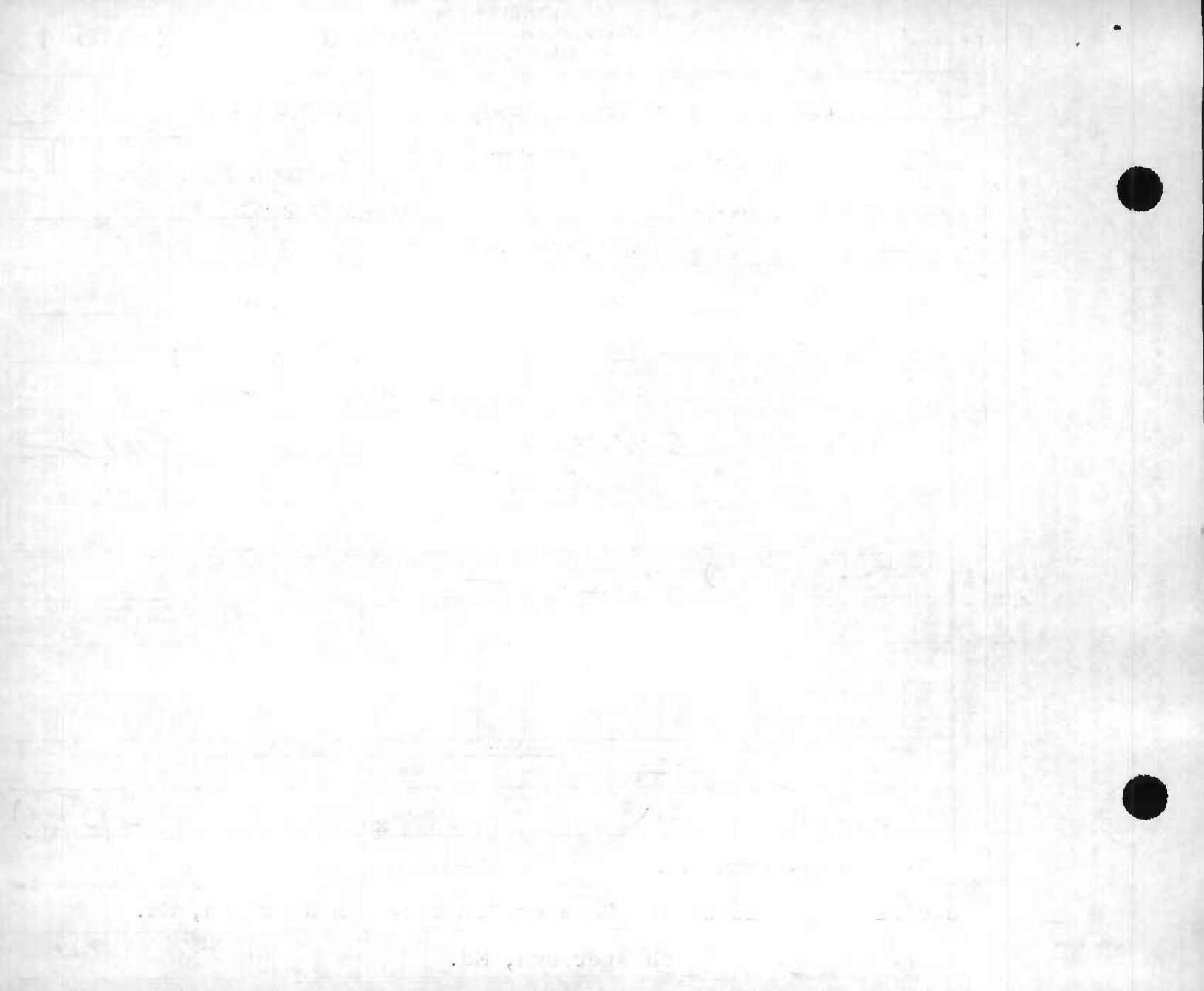
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 0 3 2 3 5 1							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Henrietta Demain					2a. DATE OF DEATH MONTH DAY YEAR December 12, 1980			2b. HOUR P M 2:58 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 4, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Charles Jones					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie NMN Layman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland 21620					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) as a result of DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from December 8, 1980 to December 12, 1980 , that (I) (we) last saw the deceased alive on December 12, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did) did not view the body after death.									
22b. SIGNATURE Dr. Robert W. Farr				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/12/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert W. Farr, M.D.				22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/80		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.			
24. FUNERAL DIRECTOR NAME J. Willie Wells				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1980		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH-17
(VR A15 ME (5))
15M 2/80

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8032352					
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR			
Arnett Sylvester Demby												12 23 19 80		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		Black		DEC 23 1961 19 YRS.		MONTH DAY YEAR		MONTHS DAYS		HOURS MIN.		12 23 19 80		9 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.				U.S.A.								Kent County, MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown				Kent & Queen Anne's Hospital				LABOR									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD.		KENT		CHESTERTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F. D#4				Box #455					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
GARNETT						Demby						ALICE GRAVES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
NO						YES						MRS. ALICE DEMBY R.F. D#4					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple injuries																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR													
				7:45 PM 12 23 19 80				passenger in auto/auto impact									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				street				U.S. Rt. 213				Centreville, Queen Anne's, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED					
Thomas D. Smith, M.D.				Deputy Chief								12/23/80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Thomas D. Smith, M.D.				111 Penn St.				Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				12-28-1980				JANES CEM.				Chestertown Kent, MD.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Bennett, W. J.				DEC 29 1980				F. J. Kelly									

100

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 5 3 REG. NO.			
1. FOR STATE REGISTRAR I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Jane Everett					2a. DATE OF DEATH MONTH DAY YEAR December 2, 1980				2b. HOUR 3:15p M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 12, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.							
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Queen Anne's Millington					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 194						
14. FATHER'S NAME FIRST MIDDLE LAST Wesley NMN Walmsley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Woodward Subers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO 217-36-0238B		17. INFORMANT ADDRESS Hospital Records- Chestertown Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1749 Carcinoma; R+ Breast; with Metastasis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Cardiovascular Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from November 23, 19 80, to December 2, 19 80, that (I) (we) lost saw the deceased alive on December 2, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Charles P. Adamo MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Dec. 3, 1980				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adamo					22e. ADDRESS Chestertown Md. 21620								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/5/80		23c. NAME OF CEMETERY OR CREMATORY Massey Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Massey Kent Md.					
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.					24b. ADDRESS 21651		25a. DATE REC'D. BY REGISTRAR DEC 8 1980		25b. REGISTRAR'S SIGNATURE R. K. Brady				

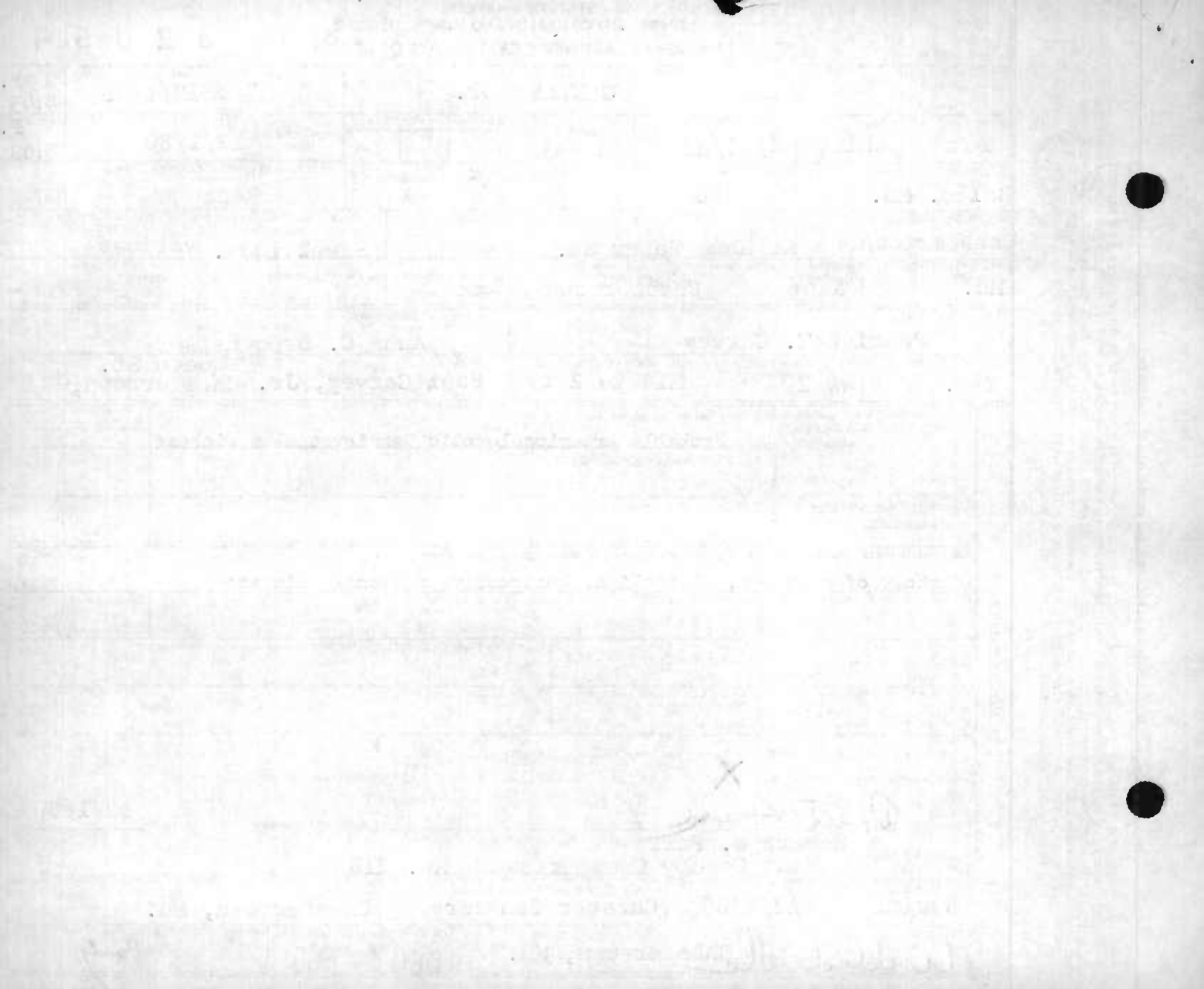
BP

XXXXXXXXXX
S17-36-0538B

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 3 5 4	
1- STATE REGISTRAR		2a. DATE OF DEATH						2b. DATE OF DEATH		2c. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		PAUL GARVEY Sr.						12/1/80		4:45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.	
male		white		2/26/28		52 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		12/1/80	
Balto. Md.		USA		WIDOWED		DIVORCED		Kent		8:00	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		At home Water St.						Steel inds. various			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Kent		Chestertown		YES NO		RIVERSIDE TERRACE			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Patrick T. Garvey						Anna G. Brookheiser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes.						WW 2		Paul Garvey, Jr. Chestertown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Probable Arteriosclerotic Cardiovascular Disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
History of seizures, Alcoholism, Obstructive Pulmonary Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES NO	
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK NOT WHILE AT WORK								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE						TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
Robert W. Farr										12/1/80	
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
Kent County Chestertown						Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				12/4/80		Chester Cemetery				Chestertown, Md.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Willis Wells						DEC 8 1980		J. Willis Wells			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 5 5				
FOR 1. STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P
Wilbur		Franklin		Hall		December 1, 1980		8:30						M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		February 9, 1909		71		YRS.		MONTHS		DAYS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.
Maryland		U.S.A.				Kent County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		Kent and Queen Anne's Hospital		Security Guard		Boat Co.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Cecil		Gerogetown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		60 School House Lane						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
William Herbert		Hannah Elizabeth		Chamberlin										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS								
No		216-14-1503		Hospital Records		Chestertown, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Ventricular fibrillation													sudden	
4100 } DUE TO, OR AS A CONSEQUENCE OF													Recent extensive myocardial infarction	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													3 days	
DUE TO, OR AS A CONSEQUENCE OF													Arteriosclerosis	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from November 29, 19 80, to December 1, 19 80, that (I) (we) last saw the deceased alive on December 1, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		DEGREE				22c. DATE SIGNED								
Thomas J. Solon		MD												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Thomas J. Solon, MD.		Chestertown, Maryland 21620												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial		12/4/80		Galena Cemetery		Galena Kent Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Edward Fellows & Son, Millington, Md.		21651		DEC 8 1980		Liston McBrayer								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

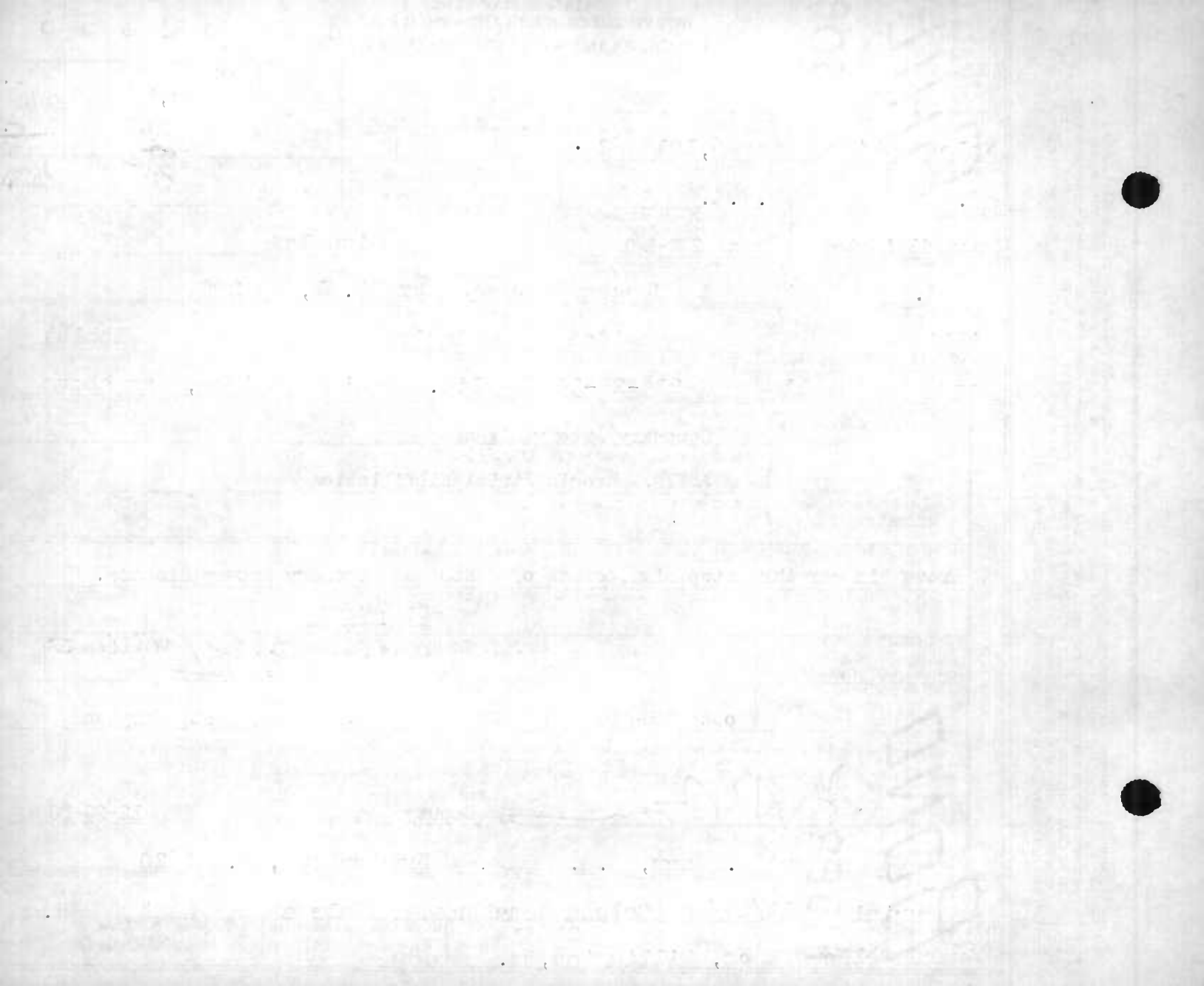
BP
DHMH - 17
(V.R. A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN CLIFTON HANIFEE			2a. DATE KNOWN OF DEATH ESTIMATED Dec, 25 19 80			2b. HOUR 9:40		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 6, 1918	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 25 12-25 19 80		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Near Millington			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 290-291			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. #1, Box 290		
14. FATHER'S NAME FIRST MIDDLE LAST William Haniffee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Tibbitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW 11		16b. SOCIAL SECURITY NO. 214-28-3606		17. INFORMANT ADDRESS Eliz. Lorraine Haniffee, as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF with (b) ASCVD, Chronic Atrial Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Drove his car thru stop sign, cause of death was coronary artery disease.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? in my opinion			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:40 A.M. 12-25 19 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I DEATH) accident was caused by his poor death from heart disease		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Route 290-291			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Near Millington, Kent, Maryland		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Robert W. Farr			TITLE (SPECIFY) Deputy			DATE SIGNED 12-29-80		
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.			ADDRESS Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/29/80		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galena Kent Md.	
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.			ADDRESS 21651			25a. DATE REC'D. BY REGISTRAR JAN 7 1981		25b. REGISTRAR'S SIGNATURE Robert W. Farr



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

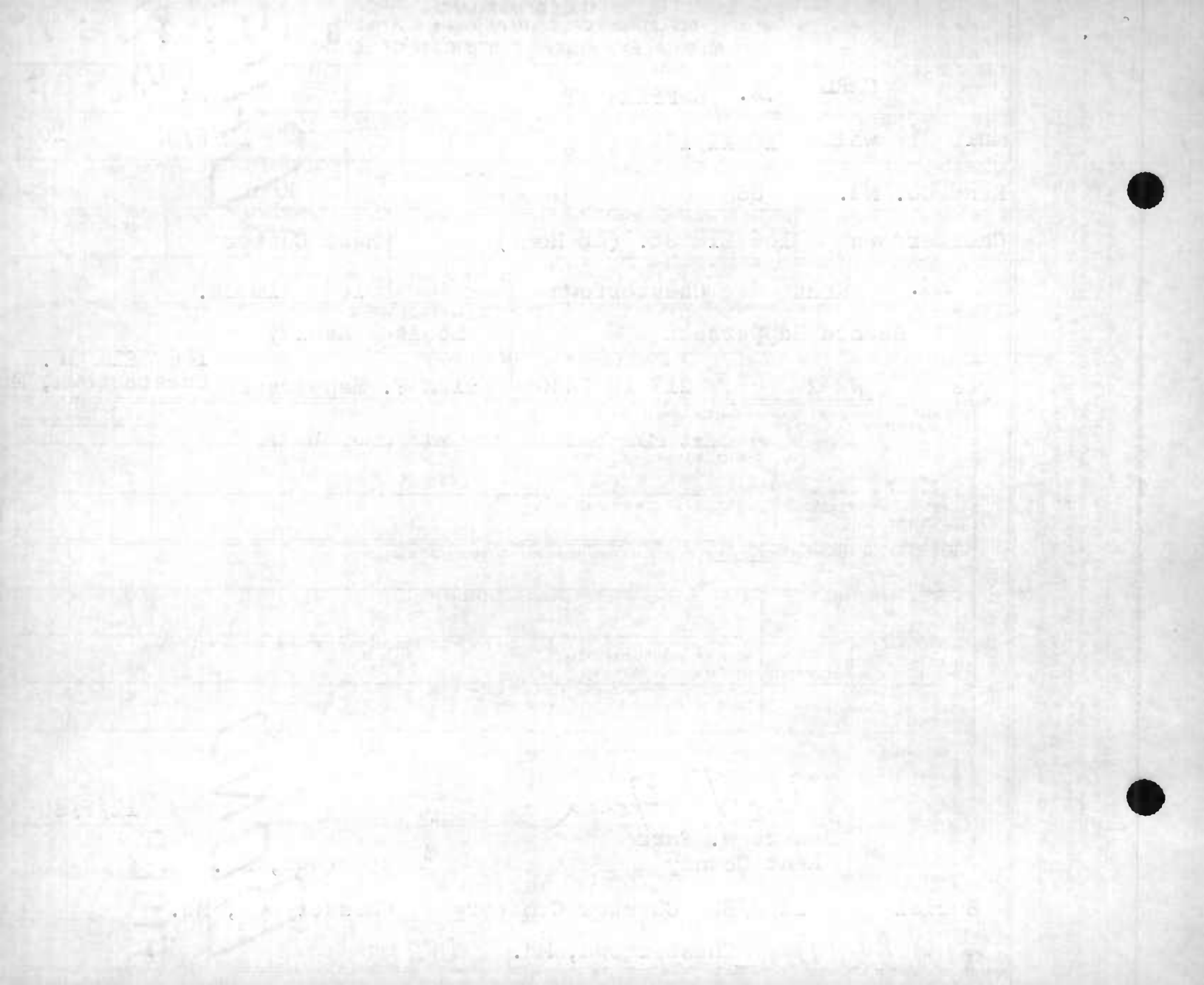
BP
DHMH - 17
(VR & 15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARL R. HAPPERSETT		2a. DATE KNOWN OF DEATH xx 12/6/80		2b. HOUR 4 P
3. SEX male	4. RACE white	5. DATE OF BIRTH 10/11/17	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	7. IF UNDER 1 YR. MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 106 Elm St. (at Home)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown
14. FATHER'S NAME Howard Happersett		15. MOTHER'S MAIDEN NAME Louise Ashley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes
16b. SOCIAL SECURITY NO. WW 2 213 10 7880		17. INFORMANT Helen F. Happersett		17b. ADDRESS 106 Elm St. Chestertown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Robert W. Farr		TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 12/7/80
EXAMINER'S NAME (TYPE OR PRINT) Kent County		ADDRESS Chestertown, Md.		
23a. BURIAL-CREATION, REMOVAL (TYPE) Burial		23b. DATE 12/9/80		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery
23d. LOCATION CITY OR TOWN Chestertown, Md.		COUNTY		STATE
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1980
				25b. REGISTRAR'S SIGNATURE P. H. Brady



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 2 3 5 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EDGAR D. HERMAN				2a. DATE OF DEATH MONTH DAY YEAR Dec. 24, 1980		2b. HOUR 2:10 AM	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9/16/1903		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Cent		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Bn. Chief Co. Fire Dept.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Kent Chestertown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS RFD # 3 Box #	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Herman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not sure			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 213 07 5723		17. INFORMANT ADDRESS RFD # 3 Mrs. Helen Herman Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) and Parkinsonism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Urinary tract infection							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) <u>the hospital</u> attended the deceased from <u>MAR 19 63</u> to <u>24 Dec 19 80</u> , that (I) <u>met</u> last saw the deceased alive on <u>24 Nov 19 80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE Harry Paul Ross				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/80		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Eastern Ave. Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Wells				ADDRESS Chestertown, Md.		25. DATE REC'D. BY REGISTRAR DEC 31 1980	
				25b. REGISTRAR'S SIGNATURE Harry Paul Ross			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

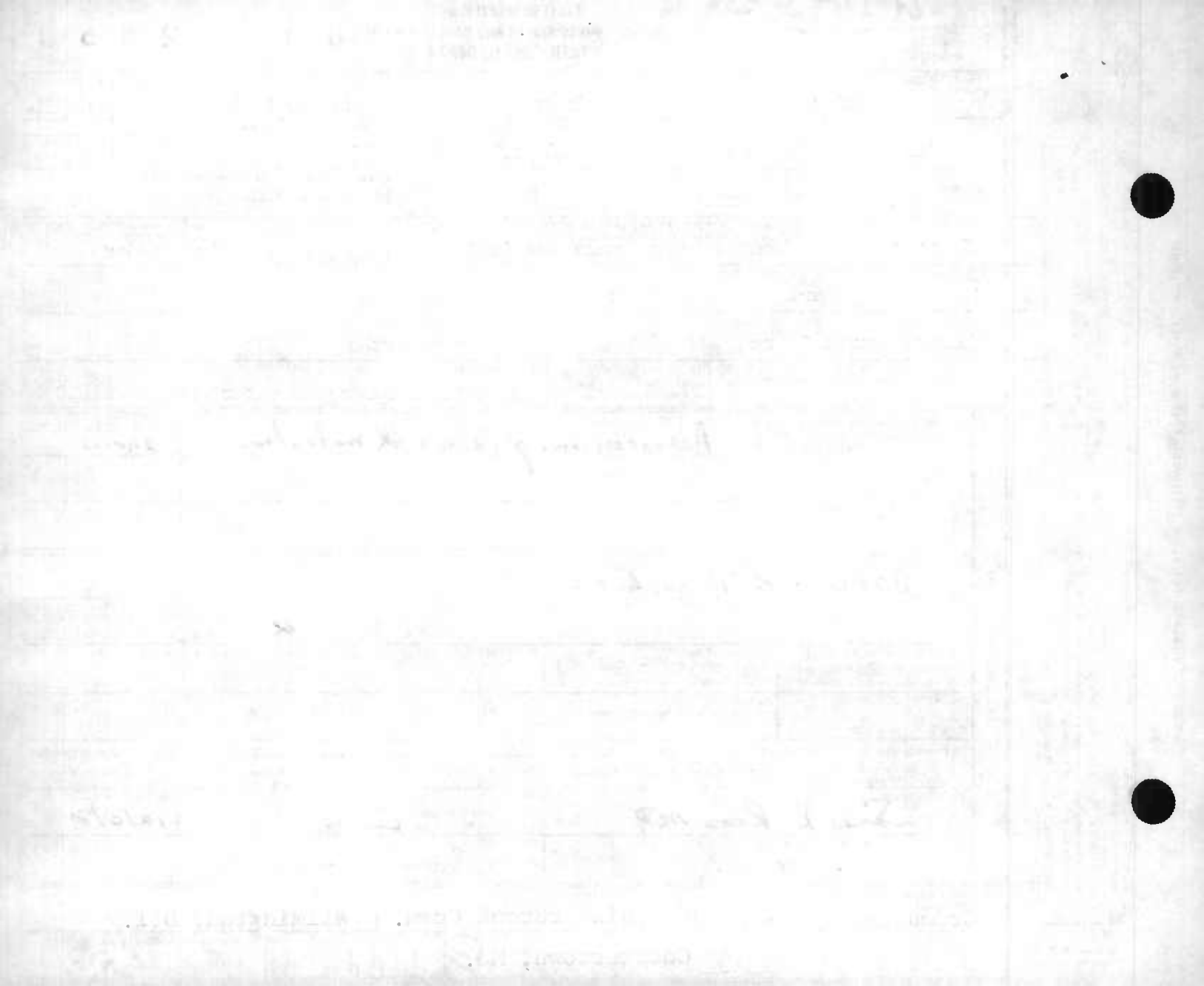
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 5 9	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) ROBERT MORRIS HEWES SR					2a DATE OF DEATH MONTH DAY YEAR Dec. 5, 1980			2b HOUR 4:45 PM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Mar 4, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 85		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.					
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) At home RFD Quaker Neck				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Constr. Engineer		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.					13b COUNTY Kent		13c CITY OR TOWN Chestertown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Robert M. Hewes					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Keese						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO WW 1		17 INFORMANT ADDRESS Robt. M. Hewes 3rd. Chestertown, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Decompensation 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic cardiovascular disease 5 years DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (the hospital) attended the deceased from 19 62 to 12/5/80 , 19____, that (I) (we) last saw the deceased alive on Nov 24 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE A.C. Dick					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/5/80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Dick					22e ADDRESS Chestertown, Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12/8/80		23c NAME OF CEMETERY OR CREMATORY St. Paul's Cem. near Chestertown, Md.		23d LOCATION CITY OR TOWN COUNTY STATE				
24 FUNERAL DIRECTOR NAME J. Willis Wells					ADDRESS Chestertown, Md.		25a DATE REC'D. BY REGISTRAR DEC 8 1980				
							25b REGISTRAR'S SIGNATURE Jeffrey McCreedy				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR		7 0 3 2 3 6 0				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martin Ayerst Ingram					2a. DATE OF DEATH MONTH DAY YEAR December 1, 1980			2b. HOUR 4:20PM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/3/1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Game Bird		12b. KIND OF BUSINESS OR INDUSTRY Feeder		
13a. STATE MD			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD # 3	
14. FATHER'S NAME FIRST MIDDLE LAST William Ayerst Ingram					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Martha Fay					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Navy			16b. SOCIAL SECURITY NO. 212-28-6553		17. INFORMANT ADDRESS Hospital Records, Chestertown, MD 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). <u>Adenocarcinoma of Colon w/ H metastases</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>COPD w/ H Bronchitis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 28, 1980</u> to <u>December 1, 1980</u> , that (I) (we) lost saw the deceased alive on <u>December 1, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Susan K. Ross M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ross M.D.					22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/3/80		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.			
24. FUNERAL DIRECTOR NAME <u>G. Wilho Wells</u>					ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 8 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 3 2 3 6 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR A M	
HAZEL		KAFADER		Dec. 24		1980		1 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female		white		March 18, 1900		80		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York State		USA				Kent		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne Hospital		Store Clerk					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Queen Anne		Chestertown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD # 1 Box # 191	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		222 09 4762		RD# 1 Chestertown, Md.	
Walter Taplin		Carrie Unknown		no					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <i>Right Cerebrovascular Accident</i>								days	
42922									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								1970	
(b) <i>Arteriosclerotic Cardiovascular Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Hypertension, Osteoarthritis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost									
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<i>Susan K. Ross, M.D.</i>				12/24/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
Susan Ross		Chestertown, Md.				<i>Tracy M. [Signature]</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		12/27/80		Bethel Meth. Cem.		Lewis Del.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
NAME		Chestertown, Md.		DEC 31 1980		<i>Tracy M. [Signature]</i>			
<i>J. Willis Wells</i>									



USA

Home & General Anne Hospital - 2000 Clark

Box 5 101

London

101 St. John

102 St. John - 101 St. John

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 3 6 2

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3a. DATE OF BIRTH		3b. AGE (IN YEARS)		3c. IF UNDER 1 YR.		3d. IF UNDER 24 HRS.	
George Willis McHenry		10/7/34		46					
4. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.	
male		white		10/7/34		46			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Md.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Kent		Farmer	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. CITY OR TOWN		15. INSIDE CITY LIMITS?	
Kennedyville		at home McHenry Farm		Md. Kent Kennedyville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD McHenry Farm	
16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Joseph A. McHenry		Sarah Willis		PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Carbon Monoxide Poisoning					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS			
no		217 30 8557		Mrs. Sarah McHenry		Kennedyville, Md			
19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21a. INJURY OCCURRED		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		4:30 PM 12/20/80		Car running in closed garage - unable to say whether or not intentional		near Kennedyville Kent Md			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED		12/20/80	
ACTUAL SIGNATURE		Robert W. Farr - Kent Co. Chestertown, Md.		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
		Burial		12/23/80		Kennedyville Cem.		Kennedyville, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. DATE REC'D. BY REGISTRAR		26b. REGISTRAR'S SIGNATURE	
Willis Wells		DEC 24 1980		Robert W. Farr		DEC 24 1980		Robert W. Farr	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHOUT 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

no

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08/80

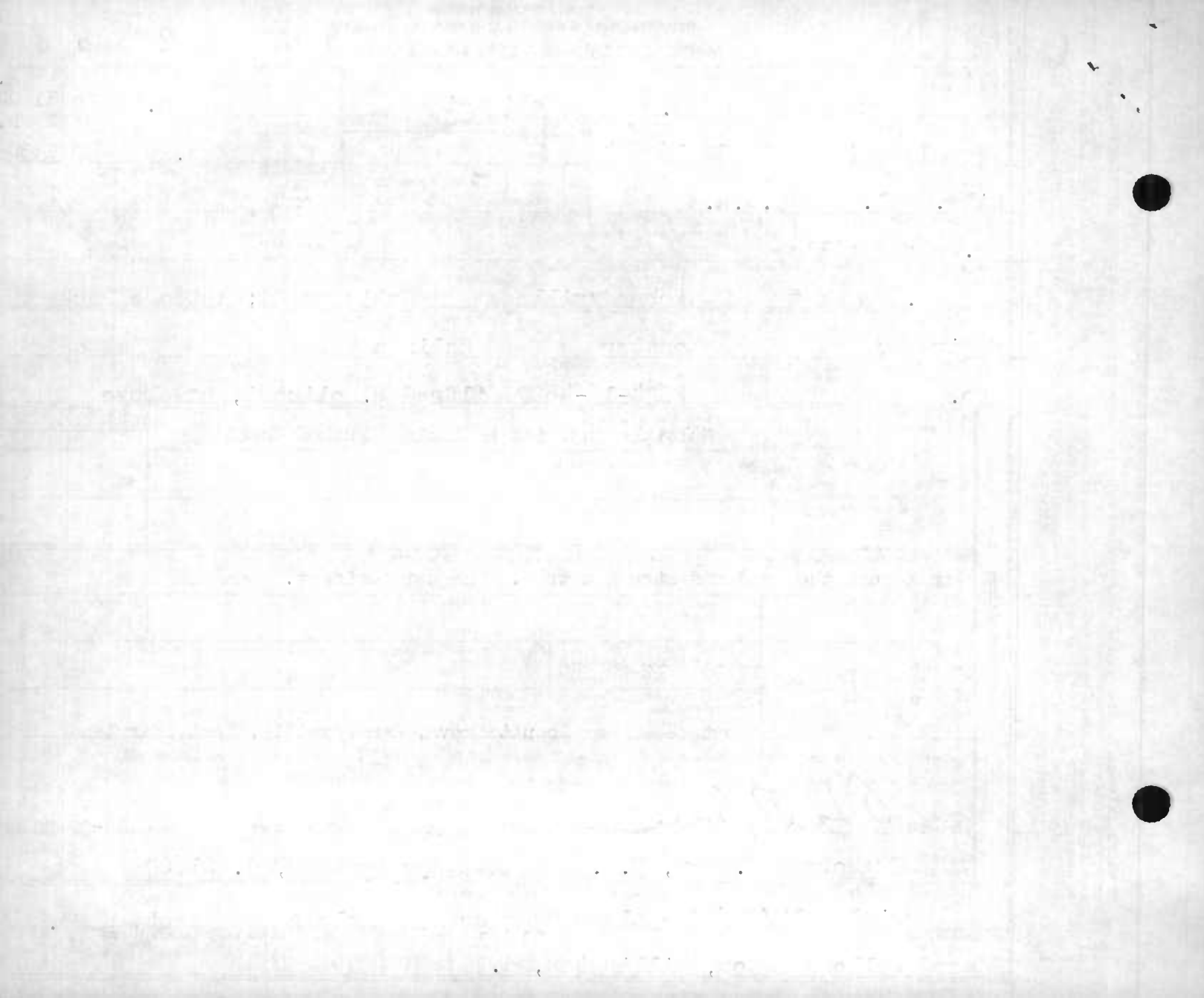
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/76

REG. NO. 3 2 3 6 3

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 3 6 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Suzanne K. Molinari										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11:00 Dec. 20, 1980										2b. HOUR			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 27 16			6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-20-80		7d. HOUR								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilm. Del.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.											
10. CITY OR TOWN OF DEATH Kennedyville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. STATE Md.										13b. COUNTY Kent		13c. CITY OR TOWN Kennedyville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Glenco Rd; Kentmore Park							
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Koester										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malinda Lawton													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.				16b. SOCIAL SECURITY NO. 004-16-4829				17. INFORMANT ADDRESS Wilfred H. Molinari, as above															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple Injuries including Crushed Chest IMMEDIATE CAUSE (a) 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Ran across the road and struck a tree. One car accident.																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 P.M. 12-20-80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Route 444 Near Locust Grove, Kennedyville, Kent, Maryland				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Robert W. Farr				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 12-22-80											
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr, M.D. ADDRESS Chestertown, Md. 21620																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/23/80		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Galena Kent Md.													
24. FUNERAL DIRECTOR NAME ADDRESS Edward Fellows & Son, Millington, Md. 21651				25a. DATE REC'D. BY REGISTRAR DEC 29 1980				25b. REGISTRAR'S SIGNATURE L. J. McCreedy															



BP
DHMH - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

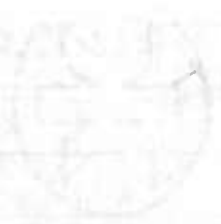
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 2 3 6 4					
1- FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Ethel Mae Parry				2a. DATE OF DEATH MONTH DAY YEAR December 28, 1980				2b. HOUR 11:00^A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Beach Road	
14. FATHER'S NAME FIRST MIDDLE LAST Stead NMN Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie NMN Gruber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-54-5521		17. INFORMANT ADDRESS Kent and Queen Anne's Hospital Medical Records Chestertown, Maryland 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF with arrhythmia & congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from December 27, 1980 to December 28, 1980 , that (I) (we) last saw the deceased alive on December 28, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.				22c. DATE SIGNED 12/29/80				22d. SIGNATURE <i>Robert W. Farr</i>	
22e. ADDRESS Chestertown, Maryland 21620				22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/29/80		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.			
24. FUNERAL DIRECTOR NAME ADDRESS Willis Wells Chestertown, Md.				25a. DATE REC'D. BY REGISTRAR DEC 31 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia McBrady</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

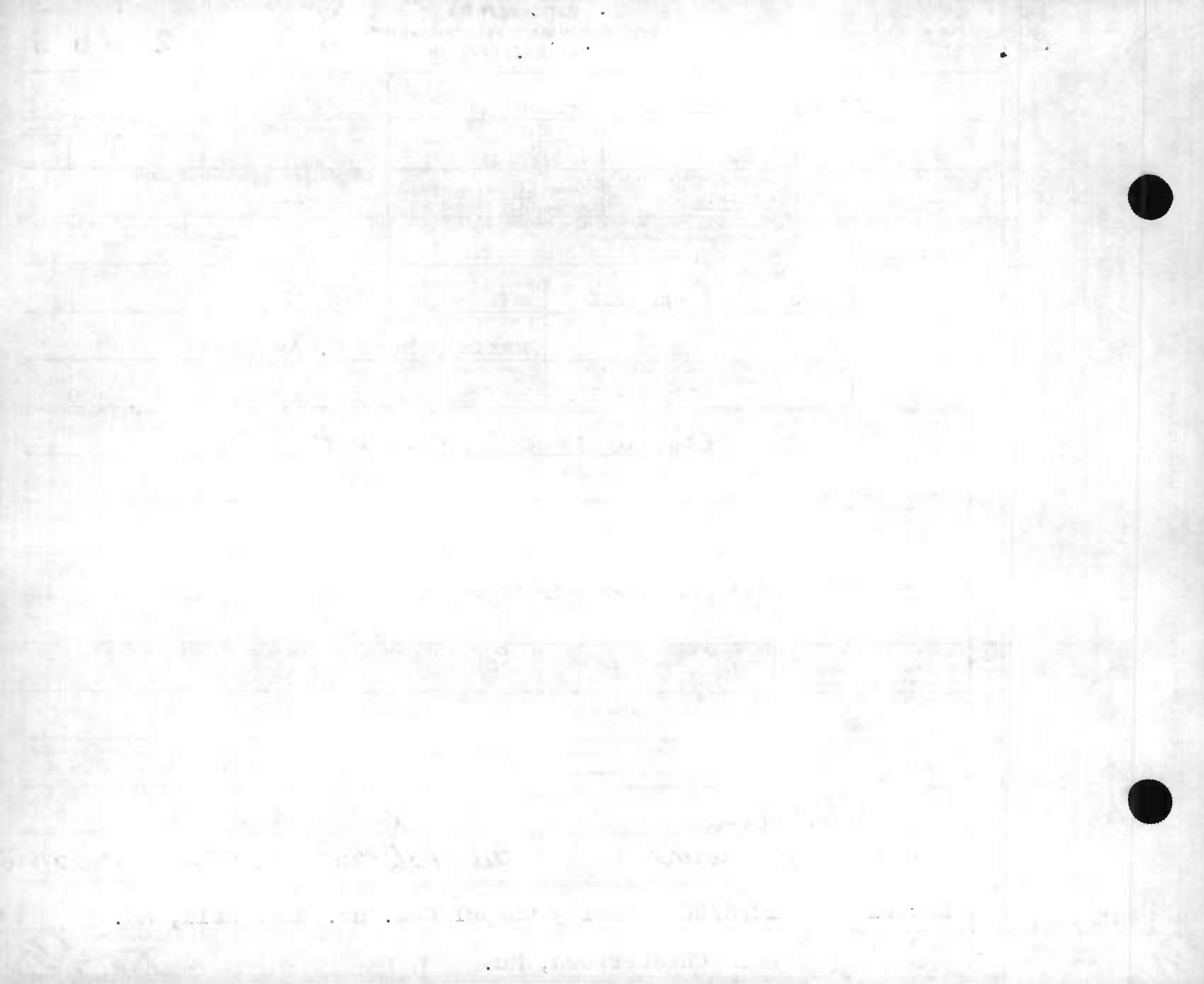
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 2 3 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lillian Myrtle Rodney			2a. DATE OF DEATH MONTH DAY YEAR 12/3/80			2b. HOUR 1:25P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 1/18/91		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife-Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. CITY OR TOWN Kent		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Box #37		
14 FATHER'S NAME FIRST MIDDLE LAST John Warner			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Ashley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Never		16b. SOCIAL SECURITY NO. 212-03-4777		17 INFORMANT ADDRESS Hospital Records Chestertown, MD 21620					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>④ lower lobe bronchopneumonia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K.K. Wun			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN.			22e. ADDRESS 216 High Street, Chestertown, Md. 21620						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/6/80		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE nr. Rock Hall, Md.		
24. FUNERAL DIRECTOR NAME J. Willis Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR DEC 8 1980		25b. REGISTRAR'S SIGNATURE Lester H. Wells	

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 2 3 6 6

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Moses James Sisco			2a. DATE OF DEATH MONTH DAY YEAR December 21 1980		2b. HOUR 3:45 PM
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR December 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KXKH Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer	12b. KIND OF BUSINESS OR INDUSTRY Truslow Farms	
13a. STATE Maryland			13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Johnny NMN Sisco			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian NMN Hawkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 214-12-6414		17. INFORMANT ADDRESS Hospital Records, Chestertown, Md. 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <u>Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>December 20</u> , 19 <u>80</u> , to <u>December 21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>December 21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>C. Gottfried Baumann</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/27/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.		22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) SHARPTOWN BURIAL		23b. DATE 12/27/80	23c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		23d. LOCATION near Rock Hall, COUNTY, STATE
24. FUNERAL DIRECTOR NAME James A. Perkins - Rock Hall, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1980		25b. REGISTRAR'S SIGNATURE <u>Hester</u>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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BP

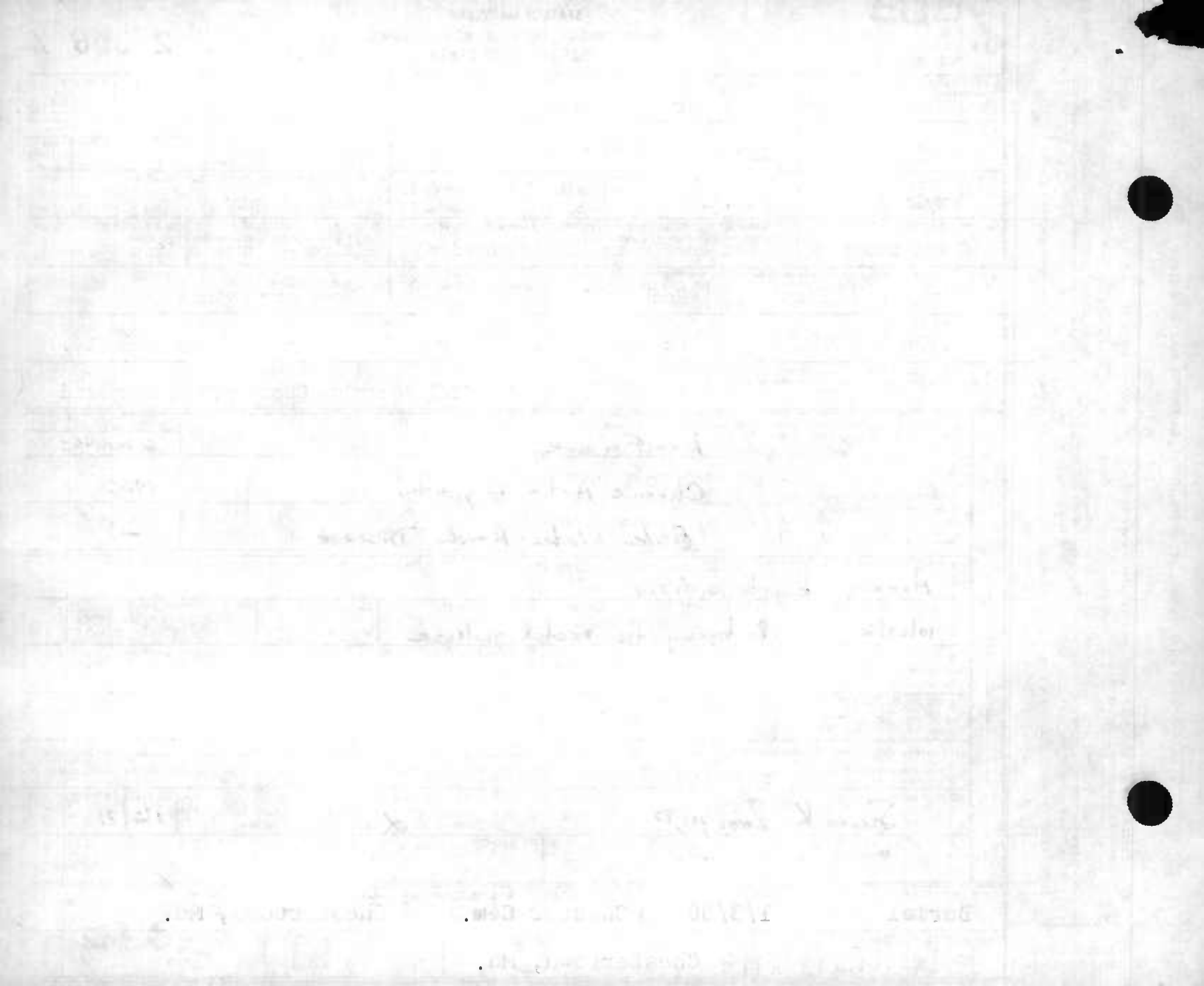


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 2 3 6 7 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Lydia Mary Stoops				2a. DATE OF DEATH December 31 1980				2b. HOUR 10:10P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH June 29 07		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.							
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent And Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Nurse's Aide		12b. KIND OF BUSINESS OR INDUSTRY --					
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Boundary Avenue			
14. FATHER'S NAME John NMN				15. MOTHER'S MAIDEN NAME Mary Anna Magrogon DEC.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-44-0668		17. INFORMANT ADDRESS 21620 Hospital Records, Chestertown, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver Failure</u> 4480 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Active Hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Osteo-Werner-Randue Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1956 -			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Anemia, Hypothyroidism</u>													
19a. DATE OF OPERATION 10/21/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectopexy for rectal prolapse				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>October 26, 1980</u> , to <u>December 31, 1980</u> , that (I) (we) lost saw the deceased alive on <u>December 31, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Susan K. Ross, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/2/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry P. Ross M.D.				22e. ADDRESS Chestertown, Maryland, 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/80		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.					
24. FUNERAL DIRECTOR NAME J. Wallis Wells				ADDRESS Chestertown, Md.				25a. DATE REC'D. BY REGISTRAR JAN 9 1981		25b. REGISTRAR'S SIGNATURE [Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 3 6 8

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Larry		MIDDLE Davis		LAST Steward Steward		2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10/29/54		6. AGE (IN YEARS (LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 23 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County, MD							
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Laborer			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD Fairlee RFD # 2					
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Steward								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vpceal Bowser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 62 8497				17. INFORMANT ADDRESS RFD # 2 Marlene Steward Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45xx 12 23 19 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pasenger in auto/auto impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE U.S. Rt. 213 Centreville, Queen Anne's, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12/23/80				MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/27/80		23c. NAME OF CEMETERY OR CREMATORY Janes Cemetery near Chestertown, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <i>James Perkins</i> Rock Hall, Md.													
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 31 1980 <i>Richard K. K...</i>													



1981 10 27

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

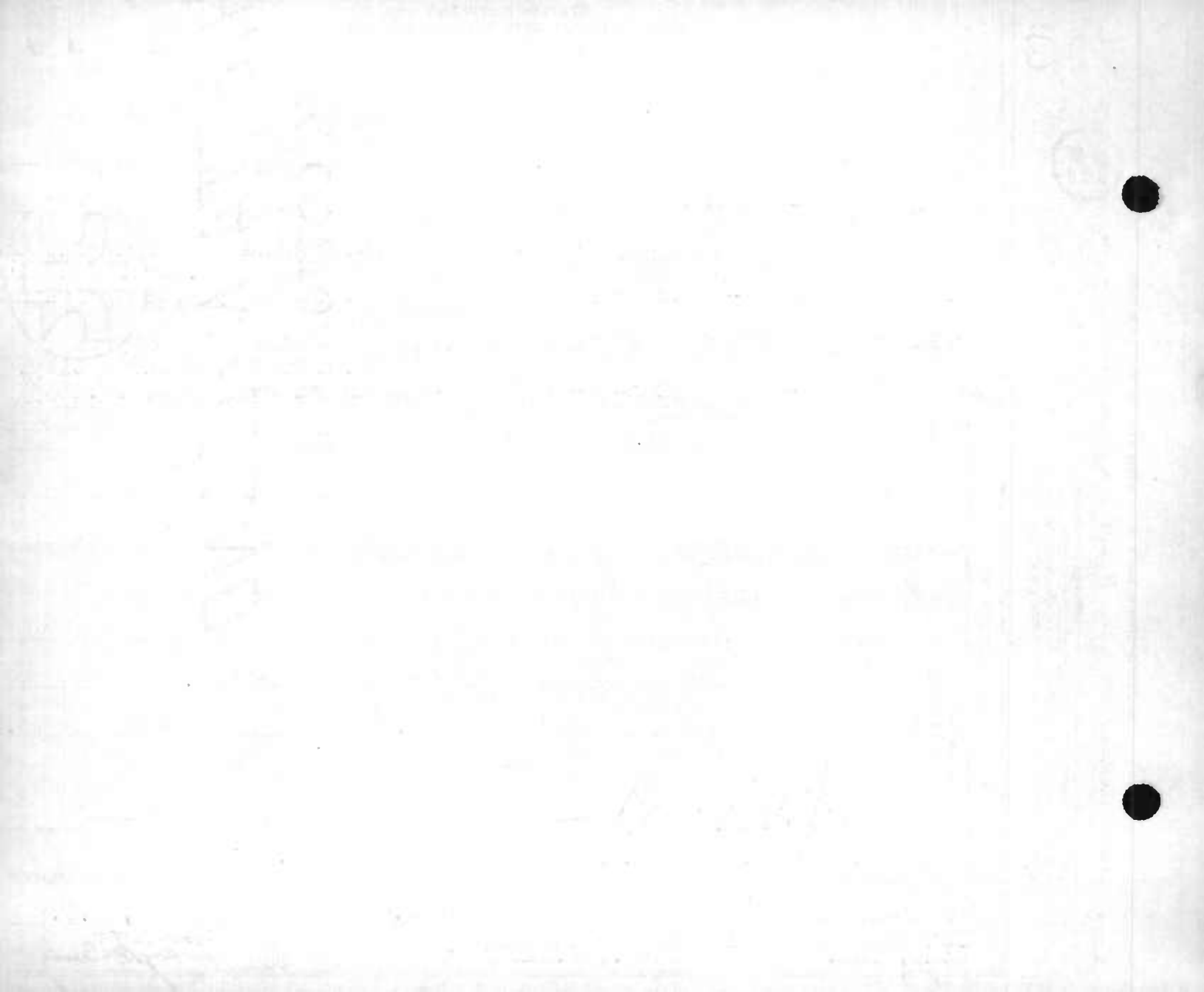
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				3. DATE OF DEATH				2b. HOUR	
WILLIAM M. STYRON								12 11 19 80				12 11 19 80				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR			
male	white	2 6 60		20 YRS.						12 11 19 80				7a. M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
North Carolina		USA								Kent County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Chestertown		Kent & Queen Anne's Hospital		Deck Hand		Dredging Co											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
North Carolina		-		Cedar Island		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P. O. Box 583, Cedar Island									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William Herbert		Veda Mae															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
No		245-21-6807		Bell-Munden Funeral Home, N.C. 28557													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple injuries																	
8147																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
2 x 4 12-11-19 80				2 12-11-19 80				Pedestrian struck by vehicle.									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				21g. COUNTY					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				road				Flatland Rd. & Stockton Startt Rd.				Kent Md.					
22a. I certify that I took charge of the remains described above, held on																	
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				SIGNED					
Ann M. Dixon, M.D.				M.D. Assistant				MEDICAL EXAMINER				12-11-80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Ann M. Dixon, M.D.				111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Removal-Burial				12/15/80				Cedar Island Comm. Cem.				Cedar Island, N.C.					
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Schlunke Funeral Home, Inc.				3331 Brehms Lane Balto., Md. 21213				DEC 16 1980				[Signature]					



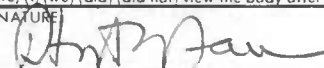

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

3 2 3 7 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Garrett Foxwell Turner			2a. DATE OF DEATH MONTH DAY YEAR December, 13, 1980			2b. HOUR 6:15 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.				
10. CITY OR TOWN OF DEATH Galena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Md.			13b. COUNTY Kent		13c. CITY OR TOWN Galena		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 84	
14. FATHER'S NAME FIRST MIDDLE LAST James Leonard Turner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 218-24-2716		17. INFORMANT ADDRESS Barbara E. Turner, as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (If any) <u>Coronary Artery Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>74</u> , to <u>12-13</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>12-13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-15-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.			22e. ADDRESS Chestertown, Md. 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/16/80		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galena Kent Md.			
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.			ADDRESS 21651		25a. DATE REC'D. BY REGISTRAR DEC 22 1980		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

